**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

PAIN & RECOVERY CLINIC
6660 AIRLINE DR
HOUSTON TX 77076

**Respondent Name**

DALLAS NATIONAL INSURANCE COMPANY

**Carrier's Austin Representative Box**

Box Number 20

**MFDR Tracking Number**

M4-12-0472-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Our facility feels that the carrier unfairly denied our services considering the fact that the carrier PAID for other dates of service with the same procedure code on this claim. The documentation used for the paid services was the SAME format used for the disputed DOS which were denied for insufficient medical documentation. We spoke with Curtis Jackson (carrier's representative) on 9/20/11 who indicated that he analyzed the documentation used and compared it to the paid DOS. He then proceeded to state that he would reprocess the bills for payment. Reference # 134954293. On October 7, 2011, we received the reconsideration EOB denying our bills for the same reason."

**Amount in Dispute:** $3,500.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The Requestor is asserting the Respondent owes them the reimbursement because similar fees for similar services has previously been provided. Respondent asserts as the attached EOB's provide the services the description of the services are not sufficient to support reimbursement. Further, the State Fee Guidelines were followed when evaluating reimbursement. Additionally, the charge was also reviewed by the Clinical Validation program in determine the reimbursement level." "The EOBs provided herein demonstrate the Responding party reimbursed the Requesting Party at the State Fee Guidelines. The charges for the medical services submitted by the Requestor exceeded the State Fees for reimbursement and therefore did not further the end of achieving effective medical cost control. The Requestor has been properly and completely reimbursed."

**Response Submitted by:** Lewis & Backhaus, PC, 5501 LBJ Freeway, Suite 800, Dallas, Texas 75240

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| October 25, 2010<br>October 26, 2010<br>October 27, 2010<br>October 29, 2010 | 97799-CP x 7 hours<br>97799-CP x 7 hours<br>97799-CP x 7 hours<br>97799-CP x 7 hours | $3,500.00 | $2,400.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out medical Fee Guidelines for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 28, 2011
   - 1 – (150) – Payer deems the information submitted does not support this level of service.
   - 2 – (W1) – Workers Compensation State Fee Schedule Adjustment.

   Explanation of benefits dated September 28, 2011
   - 1 – (CV) – MEDICAL DOCUMENTATION PROVIDED DOES NOT SUPPORT THE SERVICE (OR LEVEL OF SERVICE) BILLED. (V123)
   - 2 – (Z436) – Chronic pain management. (Z436)
   - 3 – (Z710) – The charge for this procedure exceeds the fee schedule allowance. (Z710)

### Issues

1. Does the medical documentation support the services billed?
2. Is the requestor entitled to reimbursement?

### Findings

1. Review of the documentation submitted finds that the requestor rendered 6 hours of chronic pain management services on October 25, 2010, 6 hours of chronic pain management services on October 26, 2010, 6 hours of chronic pain management services on October 27, 2010 and 6 hours of chronic pain management services on October 29, 2010 as billed. Therefore, reimbursement is recommended.
2. Per 28 Texas Administrative Code, Section §134.204(h)(5)(B), a chronic pain management program shall be reimbursed $125.00 per hour for a CARF accredited program. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes. A CARF accredited program is indicated by using the modifier –CA. The requestor did not provide the CARF accredited modifier; therefore, the monetary value of the program will be 80% of the CARF accredited value. CPT code 97799-CP will be reimbursed at $100.00 x 6 hrs = $600.00 X 4 DOS = $2,400.00. This amount is recommended.

### Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $ 2,400.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,400.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | November 3, 2011<br>Date |
|---|---|---|

## *YOUR RIGHT TO REQUEST AN APPEAL*

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.